N432 Postpartum Care Plan

Lakeview College of Nursing

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Demoghics (3 points)

Date & Time of Admission 02/09/2021 at 1830	**Patient Initials E.H.**	**Age 24 years old**	**Gender Female**
Race/Ethnicity White/Caucasian	**Occupation Community care system inc.**	**Marital Status Married**	**Allergies NKA**
Code Status Full code	**Height 5'8'' (172.7cm)**	**Weight 205lbs (93kg)**	**Father of Baby Involved Yes**

Medical History (5 Points)

Prenatal History: GTPAL: 32212

Past Medical History: Asthma and anemia

Past Surgical History: Cesarean delivery only (02/09/2021), blood transfusion service, appendectomy, and prior cesarean 4 years ago (male).

Family History: Father: Type 1 Diabetes Mellitus. Mother: hypertension

Social History (tobacco/alcohol/drugs): The patient has no social history

Living Situation: At home with her husband and daughter.

Education Level: Mother: Highschool. Father: Associates degree.

Admission Assessment

Chief Complaint (2 points): Came in for a repeat cesarean section.

Presentation to Labor & Delivery (10 points): A 24-year-old female came on the labor and delivery unit for a repeat cesarean section. The mother had a lower transverse incision. The mother had the cesarean section on 02/09/2021. The mother had some pain, but she had a spinal anesthesia. The patient also had her foley catheter removed and was having some issues after trying to void. She gets Toradol for her pain every 6 hours.

Diagnosis

Primary Diagnosis on Admission (2 points): Repeat cesarean section

Secondary Diagnosis (if applicable): Anemia and hypertension

Postpartum Course (18 points)

The postpartum period is the culmination of the childbearing experience (Ricci et al., 2017). This time is designed for maternal recovery, family attachment, and new role development (Ricci et al., 2017). The woman can feel deviation from the norm, developing postpartum conditions, or complications can become life-threatening (Ricci et al., 2017). The most common conditions that place postpartum women at risk are hemorrhage, thromboembolic disease, infections, and postpartum affective disorders (Ricci et al., 2017). Postpartum hemorrhage is a potentially life-threatening complication after a vaginal and cesarean birth (Ricci et al., 2017). It is the leading cause of maternal death (Ricci et al., 2017). A hemorrhage occurs in 5 percent of all births and is responsible for a major part of maternal mortality (Ricci et al., 2017). Postpartum hemorrhage is defined as a blood loss of greater than 500 mL after vaginal or more than 1,000 mL after a cesarean birth ().

During the postpartum period, infection is a common cause of maternal death (Ricci et al., 2017). Postpartum infection is estimated to occur in up to 8 percent of all births and accounts for 15 percent of global maternal mortality (Ricci et al., 2017). There is a higher occurrence in cesarean deliveries than in vaginal births (Ricci et al., 2017). Postpartum infection is defined as having a fever of 100.4 degrees Fahrenheit or higher after the first 24 hours after childbirth, occurring on at least 2 of the first ten days after birth (Ricci et al.,

2017). Some risk factors include surgical delivery, prolonged rupture of membranes, long labor with multiple vaginal examinations, inadequate hand hygiene, internal fetal monitoring, uterine manipulation, chorioamnionitis, instrumental birth, and obesity (Ricci et al., 2017).

A postpartum mood disorder is during the period of extraordinary physiologic, psychological, and sociocultural changes in the life of women and the family (Ricci et al., 2017). Women can have varied reactions to their childbearing experience, exhibiting a wide range of emotions (Ricci et al., 2017). They could feel fear about loss of control, they may feel scared, alone, or guilty, or as if they have failed (Ricci et al., 2017). During the postpartum period, up to 85 percent of women experience some type of mood disorder (Ricci et al., 2017). The mood disorders are classified based on their severity as postpartum or baby blues, postpartum depression, and postpartum psychosis (Ricci et al., 2017).

Some complications that can occur after having a cesarean birth could be adhesions (Rodgers et al., 2012). Adhesions cause bowel obstructions, chronic pain, infertility, and subsequent birth issues (Rodgers et al., 2012). Since this mother came in for a repeat cesarean birth, she could be at risk for cesarean scar niche, which can tether the endometrium in the old cesarean scar region and could cause a potential for accumulation of fluid or blood (Rodgers et al., 2012).

Postpartum Course References (2) (APA):

Susan Scott Ricci, Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing*. Wolters Kluwer.

Rodgers, S. K., Kirby, C. L., Smith, R. J., & Horrow, M. M. (2012). *Imaging after Cesarean Delivery: Acute and Chronic Complications.* RadioGraphics, 32(6), 1693–1712. https://doi.org/10.1148/rg.326125516

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.30	4.54	4.53	4.03	
Hgb	11.7-16.0 g/dL	10.1	9.8	8.70	The patient's hemoglobin is low due to the patient having anemia (Miller et al., 2016).
Hct	35.0-47%	31.9	31.5	28.0	The patient's hematocrit is low due to the patient being anemic (Miller et al., 2016)
Platelets	150-400	263	212	169	
WBC	4.50-11.0	12.56	12.80	15.80	The patient's White blood cell count is high due to infection related to the cesarean birth (Moldenhauer, 2019).
Neutrophils	1.80-7.70	8.79	8.79	8.24	The patients Neutrophils are high due to infection because of the cesarean birth (Moldenhauer, 2019).
Lymphocytes	1.00-4.80	2.88	2.88	10.9	The patient's Lymphocytes are high due to infection because of the cesarean birth (Moldenhauer, 2019).
Monocytes	0-0.8	0.77	0.77	6.2	The patient's Monocytes are high due to infection because of the cesarean birth (Moldenhauer, 2019).
Eosinophils	0-0.5	0.07	0.07	0.2	
Bands	N/A	N/A	N/A	N/A	N/A

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal

Blood Type	**A, B, AB, O**	**A**	**A**	**A**	
Rh Factor	**(-) or (+)**	**(+)**	**(+)**	**(+)**	
Serology (RPR/VDRL)	**Non-reactive or reactive**	**Non-reactive**	**Non-reactive**	**Non-reactive**	
Rubella Titer	**(-) or (+)**	**(+)**	**(+)**	**(+)**	
HIV	**(-) or (+)**	**(-)**	**(-)**	**(-)**	
HbSAG	**Non-reactive or reactive**	**Non-reactive**	**Non-reactive**	**Non-reactive**	
Group Beta Strep Swab	**(-) or (+)**	**(-)**	**(-)**	**(-)**	
Glucose at 28 Weeks	**<140mg/dL**	**153 (3 hours gtt 105)**	**153 (3 hours gtt 105)**	**153 (3 hours gtt 105)**	**The patient's glucose was high when check but then did a 3-hour glucose tolerance test and her glucose was within normal ranges. A glucose tolerance test measures the bodies repose to glucose (Mayo Clinic, 2018). This is typically used to test for gestational diabetes (Mayo clinic, 2018).**
MSAFP (If Applicable)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Additional Admission Labs Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Reticulocyte	**0.88-2.37%**	**1.92**	**1.92**	**1.92**	
Iron	**35-175**	**34**	**34**	**34**	**The patient's iron test was**

	ug/dL				**low because the patient is anemic (WebMD, n.d.)**
Ferritin	**4.6-204.0 ng/mL**	**11.7**	**11.7**	**11.7**	

Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Explanation of Findings
Urine Creatinine (if applicable)	**A urine analysis was not drawn for the patient.**	**A urine analysis was not drawn for the patient.**	**A urine analysis was not drawn for the patient.**	**A urine analysis was not drawn for the patient.**	**A urine analysis was not drawn for the patient.**

Lab Reference (1) (APA):

Miller, C. M., Ramachandran, B., Akbar, K., Carvalho, B., & Butwick, A. J. (2016). The Impact of Postpartum Hemoglobin Levels on Maternal Quality of Life After Delivery: *A Prospective Exploratory Study*. *Annals of Hematology*, 95(12), 2049–2055. https://doi.org/10.1007/s00277-016-2817-5

Moldenhauer, J. (2019). *Postpartum Care*. Merck Manuals Professional Edition; Merck Manuals. https://www.merckmanuals.com/professional/gynecology-and-obstetrics/postpartum-care-and-associated-disorders/postpartum-care

Mayo Clinic. (2018). Glucose tolerance test - Mayo Clinic. Mayoclinic.org; https://www.mayoclinic.org/tests-procedures/glucose-tolerance-test/about/pac-20394296

WebMD. (n.d.). What is an Iron Blood Test? WebMD. https://www.webmd.com/a-to-z-guides/iron-blood-test#1

Stage of Labor Write Up, APA format (15 points):

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	**This patient had come into the hospital for a repeated Cesarean section. Labor is typically divided into four stages such as dilation, expulsive, placental, and restorative (Ricci et al., 2017). The first stage of labor is the longest it begins with the first true contraction and ends with full dilation (Ricci et al., 2017). The first stage allows the baby to move into the birth canal (Mayo Clinic Staff, 2019). Stage two of labor begins when the cervix is completely dilated and ends with the birth of the newborn (Ricci et al., 2017). The second stage can take from a few minutes to a few hours or more to push the baby out (Mayo Clinic Staff, 2019). The third stage starts after the newborn is born and ends with the separation and birth of the placenta (Ricci et al., 2017). The third stage typically last five to thirty minutes to deliver the placenta but the whole stage can last as long as an hour (Mayo Clinic Staff, 2019). The fourth stage last one to four hours after birth (Ricci et al., 2017). The fourth stage is when the mother's body begins to stabilize after the hard work of labor and the loss of the products of conception (Ricci et al., 2017). ROM was on 02/09/2021 in 2023. The amniotic fluid was clear. This patient was in the 3rd stage of labor for 1 minute. The patient**

	also had a spinal anesthesia.
Current stage of labor	**The mother is in postpartum (repeat Cesarean section) she did not go through labor.**

Stage of Labor References (2) (APA):

Susan Scott Ricci, Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing*. Wolters Kluwer.

Mayo Clinic Staff. (2019). *Stages of Labor and birth: Baby, it's time! Mayo Clinic*; https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545

Current Medications (7 points, 1 point per completed med)
7 <u>different</u> medications must be completed

Home Medications (2 required)

Brand/Generic	**Prenatal MV-**	**Calcium**			

	Min-Fe Fum-FA DHA/ Vynatal F.A.	**carbonate/ Tums**			
Dose	**1 tablet**	**1,000-1,200 mg daily**			
Frequency	**daily**	**daily**			
Route	**PO**	**PO**			
Classification		**Antacid**			
Mechanism of Action	**The medication is a multivitamin and iron product used to prevent vitamin deficiency due to poor diet (Drugs.com, 2018).**	**Increases levels of intracellular and extracellular calcium, which is needed to maintain homeostasis, especially in the nervous and musculoskeletal systems ().**			
Reason Client Taking	**The patient is pregnant.**	**Heartburn and indigestion.**			
Contraindications (2)	**1.liver problems (Drugs.com, 2018). 2.Vitamin b12 deficiency (Drugs.com, 2018).**	**1.Hypercalcemia 2.hypophospatemia**			
Side Effects/Adverse Reactions (2)	**1.constipation (Drugs.com, 2018). 2.Diarrhea (Drugs.com, 2018).**	**1.hypotension 2.Hypercalcemia**			
Nursing	**1. Never take**	**1.Store at room**			

Considerations (2)	**more than the recommended dose of prenatal multivitamins (Drugs.com, 2018). 2. Swallow the regular tablet or capsule whole, do not break, chew, crush, or open it (Drugs.com, 2018).**	**temperature and protect from heat, moisture, and direct light. Don't freeze. 2.Monitor serum calcium level, as ordered, and elevated therapeutic response by assessing for Chvostek's and Trousseau's signs.**			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**The patient should get their iron and all the vitamin levels checked.**	**The patient should have their calcium levels checked.**			
Client Teaching needs (2)	**1.Take with a full glass of water (Drugs.com, 2018). 2.The chewable tablets must be chewed or allowed to dissolve in your mouth before swallowing (Drugs.com, 2018).**	**1.Urge patient to chew chewable tablets thoroughly before swallowing and to drink a glass of water afterwards. 2.Tell the patient to dissolve calcium citrate effervescent tablets in water and drink immediately.**			

Hospital Medications (5 required)

Brand/Generic	**Ketorolac/ Toradol**	**Methylergonovine/ methergine**	**Docusate sodium/ Colace**	**Ferrous sulfate/ Feosol**	**Aluminum and magnesium hydroxide - simethicone/ Mylanta**
Dose	**30mg**	**200mcg**	**100mg**	**325mg**	**30mL**
Frequency	**Every 6 hours**	**Once PRN**	**2 times daily (PRN)**	**Daily**	**Every 6 hours**
Route	**IV**	**IM**	**Oral**	**Oral**	**Oral**
Classification	**NSAID**	**Ergot alkaloids**	**Laxative**	**Antianemia**	**Antacid**
Mechanism of Action	**Blocks cyclooxygenase, an enzyme needed to synthesize prostaglandins (Nurse's drug handbook, 2020). They promote pain transmission from periphery to spinal cord (Nurse's drug handbook, 2020).**	**It affects the smooth muscles of a woman's uterus which would improve muscle tone as well as the strength and timing of uterine contractions (Multum, 2020).**	**Acts as a surfactant that softens stool by decreasing surface tension between oil and water in feces (Nurse's drug handbook, 2020).**	**Acts to normalize red blood cells production by binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated ferritin in reticuloendothelial cells of the bone marrow, liver, and spleen (Nurse's drug handbook, 2020).**	**It reduces gastric acid by binding with phosphate in the intestine, and then is excreted as aluminum in feces (ScienceDirect, 2012).**
Reason Client Taking	**The patient is taking this medication**	**The patient is taking this medication for heavy**	**The patient is taking this medication for**	**The patient is taking this medication is for anemia.**	**The patient is taking this medicatio**

	for pain.	**bleeding.**	**constipation**		**n for heartburn .**
Contraindications (2)	**1.Advanced renal impairment or risk of renal impairment due to volume depletion (Nurse's drug handbook, 2020). 2.NSAIDs (Nurse's drug handbook, 2020).**	**1. Grapefruit juice (Multum, 2020). 2. Pregnancy (Multum, 2020).**	**1.Fecal impaction (Nurse's drug handbook, 2020). 2.Hypersensitivity to docusate salts or their components (Nurse's drug handbook, 2020).**	**1.Hemochromatosis (Nurse's drug handbook, 2020). 2.Hemolytic anemia (Nurse's drug handbook, 2020).**	**1.Kidney problem (WebMD, 2019). 2.during pregnancy (WebMD, 2019).**
Side Effects/Adverse Reactions (2)	**1.Cerebral hemorrhage (Nurse's drug handbook, 2020). 2.Respiratory depression (Nurse's drug handbook, 2020).**	**1.Chest pain (Multum, 2020). 2.Increased blood pressure (Multum, 2020).**	**1.Dizziness (Nurse's drug handbook, 2020). 2.Syncope (Nurse's drug handbook, 2020).**	**1.Hypotension (Nurse's drug handbook, 2020). 2.Angioedema (Nurse's drug handbook, 2020).**	**1.headache (WebMD, 2019). 2.Diarrhea (WebMD, 2019).**
Nursing Considerations (2)	**1.Give IV injection over at least 15 seconds (Nurse's drug handbook, 2020). 2.Beaware that NSAIDs**	**1.Should not be used for longer than 1 week (Multum, 2020). 2.Store at room temperature away from moisture, heat, and**	**1.Assess for laxative abuse syndrome, especially in women with anorexia nervosa, depression, or personality disorders**	**1.Given irone tablets and capsules with a full glass of juice or water. Don't crush enteric coated tablets or open capsules (Nurse's drug handbook,**	**1.Store at room temperature in a dry place (Drugs.com, 2020). 2. Shake well before using (Drugs.co**

	like ketorolac should be avoided in patients with a recent MI because risk of reinfarctio n increases with NSAID therapy (Nurse's drug handbook, 2020).	**light (Multum, 2020).**	**(Nurse's drug handbook, 2020). 2. Expect excessive or long-term use of docusate to cause dependence on laxatives for bowel movements, electrolyte imbalance, osteomalacia , steatorrhea, and vitamin and mineral deficiencies (Nurse's drug handbook, 2020).**	**2020). 2.Don't give antacids, coffee, dairy products, eggs, tea, or whole-grain breads or cereals within 1 hour before or 2 hurts after iron (Nurse's drug handbook, 2020).**	**m, 2020).**
Key Nursing Assessment(s)/ Lab(s) Prior to Administratio n	**The patient needs to make sure they are not taking any NSAIDs or salicylates (Nurse's drug handbook, 2020).**	**The patient should be checked to make sure they do not have high blood pressure, toxemia od pregnancy, or are pregnant (Multum, 2020).**	**To make sure that the patient is not taking any mineral oils (Nurse's drug handbook, 2020).**	**To make sure to check iron levels, and to see if there are any drug interactions between the patient's other medications (Nurse's drug handbook, 2020).**	**Make sure to check the other medicatio ns the patient is on to see if there would be an interactio n. To check the patient diet to see if they are on a low magnesiu m diet (Drugs.co**

					m, 2020).
Client Teaching needs (2)	**1.Advise patient not to take aspirin, other NSAIDs, or other salicylates while taking ketorolac without consulting prescriber (Nurse's drug handbook, 2020).** **2. Explain that ketorolac may increase risk of serious adverse cardiovascular reactions; urge patient to seek immediate medical attention is sings or symptoms arise, such as chest pain, edema, SOB, slurring of speech (Nurse's**	**1. Do not breast feed within 12 hours after taking methylergonovine (Multum, 2020).** **2. One may need to use a breast pump to establish and maintain one's milk flow until their treatment is finished (Multum, 2020).**	**1.Tell the patient not to use docusate when she has abdominal pain, nausea, or vomiting (Nurse's drug handbook, 2020).** **2. Advise patient to take docusate with a full glass of milk or water (Nurse's drug handbook, 2020).**	**1. Urge patient to eat chicken, fish, lean red meat, and turkey, as well as foods rich in vitamin C to improve iron supplements (Nurse's drug handbook, 2020).** **2.Urge patient to avoid food that impair iron absorption, including dairy products, eggs, spinach, and high-fiber foods, such as whole grain breads and cereals and bran. Also advise her to avoid coffee or tea within 1 hour of iron intake (Nurse's drug handbook, 2020).**	**1.Take after meals and at bedtime (Drugs.com, 2020).** **2.If you take Mylanta on a regular basis, take a missed dose as soon as possible as you think about it (Drugs.com, 2020).**

	drug handbook, 2020).				

Medications Reference (1) (APA):

Drugs.com. (2018). *Prenatal multivitamins*. Drugs.com; Drugs.com. https://www.drugs.com/mtm/prenatal-multivitamins.html

2020 Nurse's drug handbook. (2020). Jones & Bartlett Learning.

Multum, C. (2020). *Methylergonovine oral and injection Uses, Side Effects & Warnings.* Drugs.com. https://www.drugs.com/mtm/methylergonovine-oral-and-injection.html

WebMD. (2019). *Drugs & Medications.* Webmd.com. https://www.webmd.com/drugs/2/drug-15586-5123/mylanta-oral/aluminum-magnesium-antacid-oral/details

ScienceDirect. (2012). *Mylanta - an overview | ScienceDirect Topics*. Www.sciencedirect.com. https://www.sciencedirect.com/topics/medicine-and-dentistry/mylanta

Drugs.com. (2020). *Mylanta: Indications, Side Effects, Warnings.* Drugs.com. https://www.drugs.com/cdi/mylanta.html

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress: The patient was not in distress.** **Overall appearance: The overall**	**A&Ox4**

appearance was good for the patient.	
INTEGUMENTARY (2 points): **Skin color: Good for race.** **Character: Good for race.** **Temperature: Warm.** **Turgor: Good.** **Rashes: The patient had no rashes.** **Bruises: The patient had no bruises.** **Wounds/Incision: The patient has a lower-transverse incision.** **Braden Score: 19** **Drains present: Y☐ N ☒** **Type: N/A**	
HEENT (0.5 point): **Head/Neck: Head and face was symmetrical at rest and with movement.** **Ears: No external drainage, symmetrical, or redness.** **Eyes: symmetrical and no drainage.** **Nose: nares are patent** **Teeth: Has all teeth, lips and oral mucosa are pink, moist and intact.**	.
CARDIOVASCULAR (1 point): **Heart sounds: The patient has a normal rhythm.** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): N/A** **Peripheral Pulses: Good and strong.** **Capillary refill: Good less than 3 seconds.** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema: the patient had some swelling under her transverse incision.**	.
RESPIRATORY (1 points): **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	**Regular depth and pattern, unlabored, expansion symmetrical, breath sounds are clear and equal bilaterally, and the patient has no cough.**
GASTROINTESTINAL (5 points): **Diet at Home: The patient diet is regular.** **Current Diet: The patient's diet is regular.** **Height: 5'8'' (172.2cm)** **Weight: 205lbs (93kg)** **Auscultation Bowel sounds: Good the**	.

bowel sounds were heard in all 4 quadrants. **Last BM: 1/24/2021** **Palpation: Pain, Mass etc.:** **Inspection: Good there was not abnormalities.** **Distention: There was no distention.** **Incisions: There was no incisions.** **Scars: There were no scars.** **Drains: The patient had no drains.** **Wounds: The patient has no wounds.**	
GENITOURINARY (5 Points): **Fundal Height & Position: 1 finger above umbilicus. It was firm and midline.** **Bleeding amount: light <10cm on pad/hr** **Lochia Color: Rubra** **Character: Good yellow with some blood in the urine.** **Quantity of urine: 500 voided through a straight catheter.** **Pain with urination: Y ☐ N ☒** **Inspection of genitals: Good minimal bleeding, there was some swelling.** **Catheter: Y ☐ N ☒** **Type: N/A** **Size: N/A** **Rupture of Membranes: 02/09/2021** **Time: 2023** **Color: Clear** **Amount: N/A** **Odor: N/A** **Episiotomy/Lacerations: the patient has not had an episiotomy or lacerations.**	**Pain with urination: the patient can not urinate but felt full so the nurse straight catheter to get urine out of the bladder. The patient had voided a little right before I left but not a lot.**
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 30** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	.
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐**	.

Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☒ **Orientation: A&O x4** **Mental Status: Good for age** **Speech: speech is clear and good.** **Sensory: good.** **LOC: Alert and awake.** **DTRs: 2- average, normal**	
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s): Support and help from her husband.** **Developmental level: Normal for age.** **Religion & what it means to pt.: The patient is Christian.** **Personal/Family Data (Think about home environment, family structure, and available family support): The patient will be going home to her husband and her toddler daughter.**	.
DELIVERY INFO: (1 point) **Delivery Date: 02/09/2021** **Time: 2024** **Type (vaginal/cesarean): cesarean** **Quantitative Blood Loss: 830 mL** **Male or Female** **Apgars: 9 at 1 minute and 9 at 5 minutes.** **Weight: 3105g** **Feeding Method: Breastfeeding**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**78**	**115/63**	**18**	**98.1**	**98%**
Labor/Delivery	**106**	**118/73**	**18**	**97.9**	**98%**
Postpartum	**81**	**116/59**	**18**	**98.4**	**97%**

Vital Sign Trends:

According to the patient's vital signs trends, there were different values during her prenatal, labor/delivery, and postpartum. In her prenatal stage all the patients vital were normal. In her labor/delivery stage her pulse was a little high at 106 when normal is 60-100 beats per minute. During her postpartum stage all her vitals were with normal ranges.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1300	**Numeric**	**The patient stated that she was in no pain at the time of my assessment.**	**0**	**The patient stated that she was in no pain at the time of my assessment.**	**The patient stated that she was in no pain at the time of my assessment.**
1700	**Numeric**	**Lower Abdomen**	**3**	**Cramping**	**The patient gets Toradol every 6 hours for her pain.**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV: Left arm** **Date on IV: 02/09/2021** **Patency of IV: infusing** **Signs of erythema, drainage, etc.: No signs of erythema or drainage.** **IV dressing assessment: Good dry and intact**	Single lumen

Intake and Output (2 points)

Intake	Output (in mL)
2970.5 mL	**1655mL**

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "T" after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
Promote urination: putting peppermint in the toilet and blowing bubbles into cup (N)	**When she feels like she needs to urinate.**	**This allows the patient to help feel the sensation to urinate.**
Providing pain relief: Toradol (T)	**Every 6 hours**	**This helps the patient with any pain she is having after her cesarean birth.**
Monitor fundal height (N)	**Every 4 hours**	**This helps us determine that the fundus us going down. Want to make sure that the fundus is nice and firm.**
Prevent constipation: Docusate sodium (T)	**2 times daily PRN**	**This helps prevent constipation after delivery.**

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? The mother is in the Postpartum phase or the fourth stage of labor.

What evidence supports this? The patient delivered her baby a day ago.

Discharge Planning (2 points)

Discharge location: Home with her husband and toddler daughter.

Equipment needs (if applicable): Breastfeeding material such as the pump.

Follow up plan (include plan for mother AND newborn): mother will come back in 2 weeks and 6 weeks to check the stitches. The baby will come back for a well-baby check in 24-48 hours.

Education needs: How to properly breastfeed (lactation specialist). She will need education on her lower transverse incision site and how to take care of it at home.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of the Nursing Diagnoses must be education related i.e. the interventions must be education for the client."

2 points for correct priority

Nursing Diagnosis (2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational (1 pt each)** Explain why the nursing diagnosis was chosen	**Intervention/Rational (2 per dx) (1 pt each)** Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours." List a rationale for each intervention and using APA format, cite the source for your rationale.	**Evaluation (1 pt each)** • How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for Acute Pain related to increased muscle contractions as evidenced by cesarean birth (Martin et al., 2016).	**A risk for acute pain was chosen because the patient went through surgery and had a lower transverse incision (Martin et al., 2016).**	**1. Assess location, nature, and duration of pain Rationale: indicates the suitable choice of treatment (Martin et al., 2016). 2. Educate proper relaxation techniques and positions for the mother to be comfortable (Martin et al., 2016). Rationale: May help decrease anxiety, tension and to promote comfort and overall, well-being (Martin et al., 2016).**	**Goal: the goal of this nursing diagnosis is to make sure that the patient is not in pain (Martin et al., 2016).**
2. Risk for infection related to	**A risk for infection was chosen**	**1. Observe for signs of fever, chills, body malaise, anorexia, and pelvic pain**	**Goal: The goal of this nursing diagnosis is to help prevent any**

decreased hemoglobin as evidenced by the patient being anemic (Martin et al., 2016).	**because the patient had a low transverse incision and there is potential that bacteria could enter the wound (Martin et al., 2016).**	**(Martin et al., 2016). Rationale: These reflect possibly signs of bacterial infection, shock or could cause death if not treated (Martin et al., 2016). 2.Administer Iron Supplement as indicated (Martin et al., 2016). Rationale: To help correct the anemia and improve the patient's wound healing (Martin et al., 2016).**	**infections from happening and help with the mother anemia (Martin et al., 2016).**
3. Potential for urinary retention related to spinal anesthesia as evidenced by failure to urinate (Green, 2016).	**Potential for urinary retention was chosen because after the foley catheter was removed the patient full but could not urinate (Green, 2016).**	**1. Monitor the patients output. If no void for four to six hours, then the patient should be straight catheter (Green, 2016). Rationale: To prevent the bladder from rupturing if the patient is not voiding. 2. Have the patient put peppermint in the toilet and blow bubbles through her cup to help with the sensation to urinary. Rationale: To empty the bladder and to prevent rupture (Green, 2016).**	**Goal: The goal of this nursing diagnosis is to help the mother void to prevent postpartum hemorrhage and her bladder from rupturing (Green, 2016).**
4. Risk for developing a blood clot related to cesarean birth and inactivity as evidenced by in developing blood clots (Green, 2016).	**Risk for developing a blood clot was chosen because the patient went through surgery and she in inactive (Green, 2016).**	**1. SCD to put on the feet to help the blood circulate through (Green, 2016). Rationale: Use it to prevent pooling and clot formation (Green, 2016). 2. Apply TED hose to help apply pressure the knee/thigh high (Green, 2016). Rationale: Use it to prevent pooling and clot formation (Green, 2016).**	**Goal: The goal of this nursing diagnosis is that the patient will remain free of any blood clots and decreasing the risk of pulmonary embolus (Green, 2016).**

Other References (APA)

Martin, P., BSN, & R.N. (2016, September 21*). 8 Postpartum Hemorrhage Nursing Care Plans*. Nurseslabs. https://nurseslabs.com/postpartum-hemorrhage-nursing-care-plans/3/

Green, C. J. (2016). *Maternal newborn nursing care plans*. Jones & Bartlett Learning.